PRINTED: 08/27/2015 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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12.00/2011							
KINDRED HOSPITAL NORTHWEST INDIANA  5454 HOHMAN AVE 5TH FL  HAMMOND, IN 46320							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	ACTION SHOULD BE COMPLETE DATE			
000 INITIAL COMMENTS		S 000					
This visit was for investigation of a State hospital complaint.							
Complaint Number: IN00148830 Unsubstantiated: lack of sufficient evidence.							
Date: 12/30/14							
Facility Number: 008899							
Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor							
Kindred Hospital Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.							
QA: claughlin 01/29/	15						
	ROVIDER OR SUPPLIER  HOSPITAL NORTHWES:  SUMMARY ST.  (EACH DEFICIENC REGULATORY OR I  INITIAL COMMENTS  This visit was for investate hospital compla  Complaint Number: IN00148830 Unsubstantiated: lac  Date: 12/30/14  Facility Number: 008  Surveyor: Jacqueline Nurse Surveyor  Kindred Hospital Nort compliance with 410 service, Indiana Hosp	DESCRIPTION  O08899  ROVIDER OR SUPPLIER  HOSPITAL NORTHWEST INDIANA  SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INF  INITIAL COMMENTS  This visit was for investigation of a State hospital complaint.  Complaint Number: IN00148830  Unsubstantiated: lack of sufficient evi Date: 12/30/14  Facility Number: 008899  Surveyor: Jacqueline Brown, R.N., Punuse Surveyor  Kindred Hospital Northwest Indiana is compliance with 410 IAC 15-1.5-6, Nu	TOP CORRECTION  O08899  ROVIDER OR SUPPLIER  HOSPITAL NORTHWEST INDIANA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for investigation of a State hospital complaint.  Complaint Number: IN00148830  Unsubstantiated: lack of sufficient evidence.  Date: 12/30/14  Facility Number: 008899  Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor  Kindred Hospital Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.	DENTIFICATION NUMBER:  008899  ROVIDER OR SUPPLIER  ROSPITAL NORTHWEST INDIANA  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for investigation of a State hospital complaint.  Complaint Number: IN00148830  Unsubstantiated: lack of sufficient evidence.  Date: 12/30/14  Facility Number: 008899  Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor  Kindred Hospital Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for investigation of a State hospital complaint.  Complaint Number: IN00148830 Unsubstantiated: lack of sufficient evidence.  Date: 12/30/14  Facility Number: 008899  Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor  Kindred Hospital Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  S 000  INITIAL COMMENTS  S 000  S 0	

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE